Public Employees Benefits Board (PEBB)

2006 Leave Without Pay (LWOP) Continuation Coverage Election

- Type or print clearly in black ink. Inaccurate, incomplete, or illegible information may delay coverage.
- List **only** eligible family members you wish to enroll.
- Make checks payable to the State Treasurer.
- Attach appropriate **dependent certification** forms if required (students age 20–24, extended dependents and disabled dependents). Forms are available at **www.hca.pebb.wa.gov**.

Section 1: SUBSCRIBER INFORMATION

Date employer coverage ended

Social security number | Sex ☐ M ☐ F | Last name | First name | Middle initial

Address | Apt./unit number

City | State | ZIP Code | County of residence

Date of birth (mm/dd/yyyy) | Work phone number (including area code) | Home phone number (including area code)

The medical plans marked with an asterisk (*) in Section 4 assign a physician or clinic code to their providers and require you to choose a primary care provider. Contact your plan for code. ➡ Physician or clinic code

Are you part-time faculty? ☐ Yes ☐ No

Select coverage you wish to continue: ☐ Medical/Dental ☐ Medical only ☐ Dental only ☐ Life insurance ☐ Long term disability (only if on educational leave)

☐ **Cancel all coverage** **Reason**_____ **Date of qualifying event**_____

Are you covered by another group medical or dental plan? ☐ Yes ☐ No Effective date_____

***Note:** If you are enrolled in Medicare Part(s) A and/or B, **attach a copy** of your Medicare card(s) along with this form.

Section 2: SPOUSE INFORMATION

*List **only** eligible family members you wish to enroll.*

Social security number | Date of marriage (mm/dd/yyyy) | Physician or clinic code | Sex ☐ M ☐ F

Last name | First name | Middle initial | Date of birth (mm/dd/yyyy)

Address (if different from subscriber) | City | State | ZIP Code

Select coverage you wish to continue: ☐ Medical/Dental ☐ Medical only ☐ Dental only

☐ **Cancel all coverage** **Reason**_____ **Date of qualifying event**_____

Are you covered by another group medical or dental plan? ☐ Yes ☐ No Effective date_____

***Note:** If you are enrolled in Medicare Part(s) A and/or B, **attach a copy** of your Medicare card(s) along with this form.

Qualifying event (please check one)

☐ Applying for disability retirement
☐ Reduction in force (RIF)
☐ Part-time faculty reduction in hours
☐ Military leave (provide date called to duty_____)
☐ Reversion employee
☐ Approved leave without pay (LWOP)
☐ Workers' compensation
☐ Approved eductional leave
☐ Seasonal employment
☐ Other _____

Section 3: FAMILY MEMBER INFORMATION

(Such as child, grandchild, etc.) ***Use additional forms for more members.*** *List* ***only*** *eligible family members you wish to enroll.*

A	Relationship to subscriber	Social security number	Physician or clinic code	☐ Disabled? ☐ Student? *Check only if age 20 or older.*	Sex ☐ M ☐ F

Last name	First name	Middle initial	Date of birth (mm/dd/yyyy)

Address (if different from subscriber)	City	State	ZIP Code

Select coverage you wish to continue: ☐ Medical/Dental ☐ Medical only ☐ Dental only

☐ **Cancel all coverage** **Reason**_____ **Date of qualifying event** _____

Are you covered by another group medical or dental plan? ☐ Yes ☐ No Effective date_____

***Note:** If you are enrolled in Medicare Part(s) A and/or B, **attach a copy** of your Medicare card(s) along with this form.

Section 4: MEDICAL PLAN SELECTION

(Check only one.)

- ☐ Community Health Plan of Washington*
- ☐ Group Health Cooperative*
- ☐ Group Health Options, Inc.*
- ☐ Kaiser Foundation Health Plan of the Northwest
- ☐ PacifiCare of Washington, Inc.*
- ☐ Regence BlueShield*
- ☐ UMP Neighborhood*
- ☐ Uniform Medical Plan PPO

These plans require the physician or clinic code of your selected primary care provider. You may find the code in the provider directory on our Web site or by calling the plan.

Section 5: DENTAL PLAN SELECTION

(Check only one.)

Preferred Provider Organization

☐ Uniform Dental Plan (Group #3000)
(may receive services *from any provider*)

Managed Care Plans

☐ DeltaCare (Group #3100)
Dentist name_____
(must receive services from *DeltaCare provider*)

☐ Regence BlueShield Columbia Dental Plan
Clinic location _____
(must receive services from *Willamette Dental Group provider*)

Note: **Delta Dental is the parent company of Washington Dental Service (WDS). WDS administers both the Uniform Dental Plan and DeltaCare.**

Section 6: LIFE INSURANCE

Current Enrollment with Agency	Coverage Amount
☒ Basic Part A ($4.74/month)	$25,000
☐ Part B – Dependent/Children	
☐ Part B – Spouse	
☐ Part B – Supplemental Spouse	_____
☐ Part C	_____
☐ Part D	_____
☐ Part E with Dependents	_____
☐ Part E without Dependents	_____

Desired Enrollment while Self-Paying

☐ I wish to maintain the same coverage I had as an active employee. _____ ***(initials)***

☐ I do not wish to continue the life coverage while eligible for self-pay; **I understand that I must reapply and submit evidence of insurability to reinstate optional life insurance when I return to work.** _____ ***(initials)***

Section 7: LONG-TERM DISABILITY

This section applies **ONLY** to employees on **educational leave**.

Current Enrollment with Agency

☒ Basic ($2.70/month)

☐ 30–Day	☐ 120–Day	☐ 300–Day
☐ 60–Day	☐ 180–Day	☐ 360–Day
☐ 90–Day	☐ 240–Day	

Desired Enrollment while Self-Paying

☐ I wish to maintain the same coverage I had as an active employee. _____ ***(initials)***

☐ I do not wish to maintain the same coverage I had as an active employee. _____ ***(initials)***

Section 8: SIGNATURE (Required)

I/we have received and read this entire *Leave Without Pay (LWOP) Election Notice* including any appendices. I/we understand that insurance coverage is determined through verification of eligibility by PEBB Benefit Services. I declare that to the best of my knowledge and belief that the individuals listed on this election form are eligible for the coverage requested. This form supersedes all forms and submissions I have previously made for coverage. A premium deposit does not guarantee coverage and will be returned if it is determined that individuals electing coverage are ineligible for coverage.

Washington State law may require disclosure of any information you submit as a public record. The HCA's Privacy Notice is available upon request by calling 360-923-2822 or online at **www.hca.wa.gov**.

Signature _____ Be sure to sign this form after printing _____ Date_____